

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0003103</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Memorial Convalescent Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>4315 Memorial Drive</u> <u>Belleville</u> <u>62226</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>St. Clair</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Mary Ann Hagler</u> (Title) <u>Administrative Assistant &amp; Director of Nursing</u>	
<b>Telephone Number:</b> <u>(618) 233-7750</u> <b>Fax #</b> <u>(618) 257-6839</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>	
<b>IDPA ID Number:</b> <u>37-0635502-002</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>03/01/64</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Eleanor Benton</u> <b>Telephone Number:</b> <u>(618) 257-5603</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number Memorial Convalescent Center# 0003103 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,420</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>108</u>	TOTALS	<u>108</u>	<u>39,420</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,140</u>		<u>23,735</u>	<u>26,875</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,140</u>		<u>23,735</u>	<u>26,875</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 68.18%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/03/64

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 108 and days of care provided 10,126Medicare Intermediary AdminaStar

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

Memorial Convalescent Center

# 0003103

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	403,390	2,400		405,790		405,790	205,592	611,382			1
2	Food Purchase		290,250		290,250		290,250		290,250			2
3	Housekeeping	125,533	11,392		136,925		136,925	38,642	175,567			3
4	Laundry		77,713		77,713		77,713	39,935	117,648			4
5	Heat and Other Utilities			72,144	72,144	(3,884)	68,260		68,260			5
6	Maintenance	55,162	13,429		68,591		68,591	7,453	76,044			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	584,085	395,184	72,144	1,051,413	(3,884)	1,047,529	291,622	1,339,151			8
	<b>B. Health Care and Programs</b>											
9	Medical Director					12,551	12,551		12,551			9
10	Nursing and Medical Records	2,227,477	144,718	20,943	2,393,138	(146)	2,392,992	54,220	2,447,212			10
10a	Therapy	460,267	18,784		479,051		479,051	211,745	690,796			10a
11	Activities	74,662	3,640		78,302		78,302		78,302			11
12	Social Services	60,238			60,238		60,238	43,902	104,140			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Disposable Diapers		44,760		44,760		44,760	(13,526)	31,234			15
16	<b>TOTAL Health Care and Programs</b>	2,822,644	211,902	20,943	3,055,489	12,405	3,067,894	296,341	3,364,235			16
	<b>C. General Administration</b>											
17	Administrative	73,787			73,787	(12,551)	61,236		61,236			17
18	Directors Fees											18
19	Professional Services			3,953	3,953		3,953	(53)	3,900			19
20	Dues, Fees, Subscriptions & Promotions			5,640	5,640		5,640		5,640			20
21	Clerical & General Office Expenses	109,444		15,841	125,285	2,610	127,895	8,126	136,021			21
22	Employee Benefits & Payroll Taxes			658,140	658,140		658,140	94,745	752,885			22
23	Inservice Training & Education											23
24	Travel and Seminar			202	202		202		202			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,040	50,040		50,040		50,040			26
27	Other (specify):* Bad Debts			57,749	57,749		57,749	(57,749)				27
28	<b>TOTAL General Administration</b>	183,231		791,565	974,796	(9,941)	964,855	45,069	1,009,924			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,589,960	607,086	884,652	5,081,698	(1,420)	5,080,278	633,032	5,713,310			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

Memorial Convalescent Center

#0003103

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			115,724	115,724		115,724	105,933	221,657			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Loss on Disposal			170	170		170		170			36
37	<b>TOTAL Ownership</b>			115,894	115,894		115,894	105,933	221,827			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	73,491	242,992		316,483		316,483	47,906	364,389			39
40	Barber and Beauty Shops					1,420	1,420		1,420			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*	58,117	49,937	10,124	118,178		118,178	61,747	179,925			43
44	<b>TOTAL Special Cost Centers</b>	131,608	292,929	69,254	493,791	1,420	495,211	109,653	604,864			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,721,568	900,015	1,069,800	5,691,383		5,691,383	848,618	6,540,001			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Memorial Convalescent Center

# 0003103

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,722)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(676)	6		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,749)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Collection Fees	(53)	19		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,200)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	917,818		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 917,818		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 848,618		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x	1,420	40	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,420		47

Memorial Convalescent CenterID# 0003103Report Period Beginning: 01/01/2002Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

# 0003103

**Report Period Beginning:**

**01/01/2002**

**Ending:**

12/31/2002

[illegible]



Facility Name & ID Number Memorial Convalescent Center# 0003103Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Memorial Hospital	Belleville	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	22 Employee Benefits	\$ 658,140	Memorial Hospital	0.00%	\$ 752,885	\$ 94,745 1
2	V	21 Administration	127,895			136,021	8,126 2
3	V	6 Maintenance	68,591			76,720	8,129 3
4	V	4 Laundry	77,713			117,648	39,935 4
5	V	3 Housekeeping	136,925			175,567	38,642 5
6	V	1 Dietary	405,790			611,382	205,592 6
7	V	15 Central	44,760			31,234	(13,526) 7
8	V	39 Pharmacy, Medical Supplies	316,483			364,389	47,906 8
9	V	43 Ancillary services	118,178			179,925	61,747 9
10	V	12 Social Service	60,238			104,140	43,902 10
11	V	10 Medical Records	1,274			55,494	54,220 11
12	V	10a Therapy	479,051			690,796	211,745 12
13	V	30 Depreciation	115,894			232,549	116,655 13
14	Total		\$ 2,610,932			\$ 3,528,750	\$ * 917,818 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	Not Applicable										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Memorial Hospital  
 Street Address 4500 Memorial Drive  
 City / State / Zip Code Belleville, IL 62226  
 Phone Number (618) 233-7750  
 Fax Number (618) 257-6839

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	22	Employee Benefits	Salaries	66,784,789	2	\$ 20,416,010	\$ 606,980	2,302,139	\$ 703,760	1
2	21	Communications	Phones	1,011	2	563,081	199,050	6	3,342	2
3	21	Data Processing	Resources	10,000	2	1,919,821	716,406	75	14,399	3
4	21	Materials Management	Stores Requisitions	5,128,934	2	635,473	423,064	106,096	13,145	4
5	21	Administration	Accumulated Cost	134,230,512	2	9,254,238	3,024,410	3,281,071	226,206	5
6	6	Plant	Square Feet)	18,453	1	165,973	55,162	16,119	144,980	6
7	4	Laundry	Pounds	2,508,432	2	947,433	372,789	311,487	117,648	7
8	3	Housekeeping	Hours of Service	121,418	2	2,397,148	1,471,088	16	316	8
9	3	Housekeeping MCC	Square Feet)	17,705	1	192,495	125,533	16,119	175,251	9
10	1	Dietary	Patient Meals	285,475	2	3,192,477	1,697,089	80,625	901,632	10
11	22	Emp Ben/Cafeteria	Employee Meals	142,561	2	949,853	413,724	7,373	49,125	11
12	10	Medical Records	Time Spent	10,000	2	3,264,325	1,725,555	170	55,494	12
13	12	Social Service	Time Spent	121,264	2	732,804	473,044	17,233	104,140	13
14	43	Radiology	Revenue	28,986,430	2	8,350,280	2,607,058	104,167	30,008	14
15	43	Laboratory	Revenue	54,390,958	2	11,792,206	3,658,738	464,063	100,611	15
16	43	Nutritional Support	Revenue	687,830	2	469,145	198,755	57,395	39,147	16
17	43	EKG	Revenue	14,250,344	2	2,649,752	874,744	54,634	10,159	17
18	39	Drugs & IV Therapy	Revenue	19,456,781	2	8,852,362	1,818,050	722,872	328,889	18
19	39	Medical Supplies Sold	Revenue	2,404,661	2	3,589,694	602,751	44,704	66,734	19
20	10a	Respiratory Care	Revenue	11,714,905	2	3,100,363	1,666,468	214,781	56,842	20
21	10a	Physical Therapy	Revenue	11,005,442	2	5,001,288	2,619,927	901,587	409,715	21
22	10a	Occupational Therapy	Revenue	1,243,828	2	428,839	269,214	621,074	214,130	22
23	10a	Speech Therapy	Revenue	136,707	2	97,566	54,420	14,165	10,109	23
24	30	Capital Costs	See Attached	12,458,731	2	12,458,731	0	232,549	232,549	24
25	TOTALS					\$ 101,421,357	\$ 25,674,019		\$ 4,008,331	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2				Not Applicable								2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ \_\_\_\_\_      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Memorial Convalescent Center**# **0003103** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Memorial Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0003103

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (     ) \_\_\_\_\_ FAX #: (     ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>          </u>	\$ <u>          </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
24,001

B. General Construction Type:

Exterior
Brick

Frame

Number of Stories
1

C.
Does the Operating Entity?

☒
(a) Own the Facility

☐
(b) Rent from a Related Organization.

☐
(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒
(a) Own the Equipment

☐
(b) Rent equipment from a Related Organization.

☐
(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
YES
☒
NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1964	\$ 40,000	1
2					2
3	TOTALS			\$ 40,000	3

Facility Name &amp; ID Number Memorial Convalescent Center

# 0003103

Report Period Beginning:

01/01/2002

Ending: 12/31/2002

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	\$ 882,395	\$ 9,016	33.3	\$	(9,016)	\$ 882,395	4
5			1966		144,150	709	30.89		(709)	144,150	5
6			1979		237,657	1,643	20.28	1,643		218,236	6
7			1980		2,695					2,695	7
8			1981		18,583					18,583	8
9		Improvement Type**									9
10		Electrical Upgrade		1996	25,549	1,359	18.79	1,359		8,838	10
11		Walking Track		1998	7,690	513	15	513		2,309	11
12		Roof Replacement		1998	68,383	6,838	10	6,838		30,771	12
13		Change in electrical power system		1998	5,479	365	15	365		1,642	13
14		7 1/2 ton A/C unit		1998	14,326	955	15	955		4,298	14
15		Air furnace		1998	15,226	1,015	15	1,015		4,568	15
16		5 ton air handler		1998	14,900	993	15	993		4,469	16
17		Electrical work-boiler rm,A/C unit,relamp,auto tr switch		1998	91,162	4,557	20	4,557		20,510	17
18		Air handling unit installed		1994	12,048	803	15	803		6,826	18
19		Repair parking lot		1994	83,569	5,243	10.85	5,243		63,003	19
20		Landscaping		1994	4,200	280	15	280		2,380	20
21		Flooring replaced in patient room		1993	56,883	3,792	15	3,792		36,025	21
22		Activity Therapy Renovation		1993	41,940	2,264	12.83	2,264		26,540	22
23		Condensing unit		1993	4,684	312	15	312		2,964	23
24		Air conditioners		1993	6,589	439	15	439		4,171	24
25		Upgrade lighting		1993	4,516	226	20	226		2,147	25
26		Renovate patient room & nurse station		1992	42,370	2,322	17.99	2,322		24,705	26
27		Renovate patient rooms-doors,wallcovering,bldg		1992	75,908	721	10.49	721		72,668	27
28		Roof top air conditioner		1992	4,342	289	15	289		3,040	28
29		Renovate business office		1991	35,387	1,817	18.5	1,817		23,694	29
30		Patient rooms-drywall,ceiling,paint		1991	39,835	2,427	14.55	2,427		30,856	30
31		Demolish back lounge		1991	752	50	15	50		575	31
32		Brickwork chimney		1991	5,225	348	15	348		4,003	32
33		Paint exterior tower		1991	1,185		5			1,185	33
34		ITE Panel		1991	995	50	20	50		575	34
35		Air conditioner		1991	6,580	438	15	438		5,042	35
36		Telephone wiring		1991	924	3	10	3		924	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number    Memorial Convalescent Center

#    0003103

Report Period Beginning:

01/01/2002    Ending:    12/31/2002

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Circuit breaker	1991	\$ 1,011	\$ 51	20	\$ 51		\$ 580		37
38	Cubicles & track	1990	9,899		5			9,899		38
39	Half Glass door windows	1989	601	40	15	40		540		39
40	Roofing	1988	55,463		10			55,463		40
41	Air conditioner	1988	1,556		5			1,556		41
42	Air conditioner	1987	1,551		5			1,551		42
43	Remove bathroom showers	1987	17,966	474	15.56	474		15,883		43
44	Cooling units	1986	3,854		9			3,854		44
45	Cooling units	1985	5,644		10			5,644		45
46	Resurface road	1985	39,780		15			39,780		46
47	Guttering	1985	2,116		20			2,116		47
48	Metal door frames	1984	5,751	288	20	288		5,318		48
49	Water & Sewer lines	1984	2,807	140	20	140		2,591		49
50	Sprinkle system	1978	27,578	1,103	25		(1,103)	27,578		50
51	Sprinkle system	1977	1,585		20			1,585		51
52	Cooling unit & heat detectors	1974	5,468					5,468		52
53	Air conditioners & beauty shop	1973	1,210					1,210		53
54	Heating & cooling equipment	1972	53,944					53,944		54
55	Smoke detector	1971	5,800					5,800		55
56	Land Improvements	1968	4,238		40	106	106	3,763		56
57	Vinyl flooring restrooms	1999	2,441	488	5	488		1,708		57
58	Reznor make up air unit	1999	15,432	1,543	10	1,543		5,401		58
59	Electrical work	1999	2,566	128	20	128		448		59
60	New door physical therapy	2000	3,735	249	15	249		623		60
61	Porch columns	2000	5,965	398	15	398		995		61
62	Repair walls	2001	2,080	139	15	139		208		62
63	Electrical work	2001	4,191	210	20	210		315		63
64	Electrical work	2001	16,778	839	20	839		1,258		64
65	Window Replacement	2002	113,345	3,778	15	3,778		3,778		65
66	Storage Addition	2002	253,195	8,443	15	8,443		8,443		66
67	Storage Addition	2002	4,227	423	5	423		423		67
68	Storage Addition	2002	1,259	630	1	630		630		68
69	Fire Alarm/Nurse Call Replacement	2002	4,473	149	15	149		149		69
70	TOTAL (lines 4 thru 69)		\$ 2,633,636	\$ 69,300		\$ 58,578	\$ (10,722)	\$ 1,923,289		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,633,636	\$ 69,300		\$ 58,578	\$ (10,722)	\$ 1,923,289	1
2 Fire Alarm/Nurse Call Replacement	2002	350	58	3	58		58	2
3 Fire Alarm/Nurse Call Replacement	2002	1,001	100	5	100		100	3
4 Fire Alarm/Nurse Call Replacement	2002	48,125	2,407	10	2,407		2,407	4
5 Fire Alarm/Nurse Call Replacement	2002	490	16	15	16		16	5
6 Fire Alarm/Nurse Call Replacement	2002	61,775	1,543	20	1,543		1,543	6
7 Patient Wardrobe Units	2002	67,813	2,261	15	2,261		2,261	7
8 Patient Wardrobe Units	2002	5,824	291	10	291		291	8
9 Heating and Cooling Unit	2002	7,702	257	15	257		257	9
10 8" Faucets	2002	5,318	133	20	133		133	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,832,034	\$ 76,366		\$ 65,644	\$ (10,722)	\$ 1,930,355	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 303,971	\$ 26,408	\$ 26,408	\$	11.5	\$ 217,345	71
72	Current Year Purchases	9,384	656	656		7.2	656	72
73	Fully Depreciated Assets	221,300					221,300	73
74								74
75	TOTALS	\$ 534,655	\$ 27,064	\$ 27,064	\$		\$ 439,301	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	\$ 49,174	\$ 12,294	\$ 12,294	\$	4	\$ 30,734	76
77										77
78										78
79										79
80	TOTALS			\$ 49,174	\$ 12,294	\$ 12,294	\$		\$ 30,734	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,455,863	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 115,724	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,002	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,722)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,400,390	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Improvements	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$                      Description:                                     

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2003 \$                     

13.                      /2004 \$                     

14.                      /2005 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$ 171,757		\$	3,651		\$ 175,408	1
2	Licensed Speech and Language Development Therapist	10a	hrs	5,410			671		6,081	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	252,290			5,077		257,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	73,491			242,992		316,483	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 502,948		\$	252,391		\$ 755,339	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Memorial Convalescent Center

# 0003103

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 325	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	656,559		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,415		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 664,299	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,707,101		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	575,528		16
17	Accumulated Depreciation (book methods)	(2,375,338)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Land Improvements</u>	152,289		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,099,580	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,763,879	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 99,487	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,915		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 232,402	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Reserve for Self Insurance</u>	346,000		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 346,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 578,402	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,185,477	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,763,879	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 615,478</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 615,478</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>49,895</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 49,895</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Interfund Transfer - Hospital</b>	<b>520,104</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ 520,104</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,185,477</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,800,561	1
2	Discounts and Allowances for all Levels	(1,262,086)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,538,475	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,536,826	6
7	Oxygen	214,781	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,751,607	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,420	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	722,872	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	464,063	19
20	Radiology and X-Ray	104,167	20
21	Other Medical Services	156,733	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,449,255	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,265	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,265	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Chapel Maintenance	676	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 676	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,741,278	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,051,413	31
32	Health Care	3,055,489	32
33	General Administration	974,796	33
<b>B. Capital Expense</b>			
34	Ownership	115,894	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	434,661	35
36	Provider Participation Fee	59,130	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,691,383	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	49,895	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 49,895	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Memorial Convalescent Center# 0003103Report Period Beginning: 01/01/2002Ending: 12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	418	574	\$ 18,747	\$ 32.66	1
2	Assistant Director of Nursing	1,766	2,052	62,598	30.51	2
3	Registered Nurses	28,048	30,259	723,161	23.90	3
4	Licensed Practical Nurses	10,353	11,365	220,469	19.40	4
5	Nurse Aides & Orderlies	73,917	81,060	948,301	11.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,225	5,733	74,662	13.02	10
11	Social Service Workers	2,909	3,152	60,238	19.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,113	40,584	403,390	9.94	15
16	Dishwashers					16
17	Maintenance Workers	3,387	3,755	55,162	14.69	17
18	Housekeepers	11,178	12,586	125,533	9.97	18
19	Laundry					19
20	Administrator	1,133	1,557	49,762	31.96	20
21	Assistant Administrator					21
22	Other Administrative	188	210	11,474	54.64	22
23	Office Manager					23
24	Clerical	20,419	23,205	362,371	15.62	24
25	Vocational Instruction	8,168	9,121	171,757	18.83	25
26	Academic Instruction					26
27	Medical Director	100	107	12,551	117.30	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	97	107	1,274	11.91	31
32	Other Health Care(specify)	19,716	22,532	420,118	18.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	223,135	247,959	\$ 3,721,568 *	\$ 15.01	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	49	15,208	ln 10,col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Physician Advisor</u>	61	7,200	ln 10,col 3	46
47	<u>Psychologist</u>	1	100	ln 10,col 3	47
48	<u>Physician Reviewer</u>		2,570	ln 10,col 3	48
49	TOTAL (lines 35 - 48)	111	\$ 25,078		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,855	96,719	Ln 10 col 1	52
53	TOTAL (lines 50 - 52)	5,855	\$ 96,719		53

<b>Facility Name &amp; ID Number</b>	<b>Memorial Convalescent Center</b>
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# 0003103

Report Period Beginning: 01/01/2002

**Ending: 12/31/2002**

## XIX. SUPPORT SCHEDULES

[illegible]

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number Memorial Convalescent Center

STATE OF ILLINOIS

# 0003103

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Health Care \$5,481
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7.2
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,234 Line 15
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 59,130  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 49,125 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,082,346
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Not Applicable  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: BKD,LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.